No. 89-1048

In The

Supreme Court of the United States

October Term, 1989

FMC CORPORATION

Petitioner,

vs.

CYNTHIA ANN HOLLIDAY

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

BRIEF FOR THE PETITIONER

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QUESTION PRESENTED

Whether ERISA's express preemption provisions, as interpreted in *Metropolitan Life v. Massachusetts*, prohibit states from applying state insurance regulations directly to self-funded employee welfare benefit plans?

PARTIES TO THE PROCEEDINGS

Petitioner, FMC Corporation, is a Delaware corporation with its principal place of business in Illinois. FMC's subsidiaries include: FMC do Brasil S.A., FMC Mid-Atlantic Investments Limited, Mid-Atlantic Acceptance Company Limited, FMC Gold Company, FMC Paradise Peak Corporation, FMC Jerritt Canyon Corporation, FMC International, A.G., FMC Wyoming Corporation, Foret, S.A., Lithium Corporation of America. Respondent, Cynthia Ann Holliday, is an individual and citizen of Pennsylvania.

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OPINIONS BELOW

The opinion of the United States District Court for the Western District of Pennsylvania (C1) is not officially reported. The opinion of the United States Court of Appeals for the Third Circuit is reported at 885 F.2d 79 (3d Cir. 1989). (A1).*

JURISDICTION

The court of appeals rendered its opinion and entered judgment in favor of Defendant/Respondent, Cynthia Ann Holliday, on September 11, 1989. (A1). FMC Corporation ("FMC") filed a Motion for Rehearing *En Banc* on September 21, 1989, which was denied by the court of appeals on October 5, 1989. (B1).

This Court has jurisdiction over this appeal pursuant to 28 U.S.C. § 1254(1) and its order dated February 20, 1990, granting FMC's Petition for a Writ of Certiorari.

STATUTES INVOLVED

Section 514(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), provides:

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* The following opinions or orders have been reprinted in FMC's Petition for Writ of Certiorari: Opinion of the court of appeals – A1. Order of the court of appeals denying rehearing – B1. Opinion of the district court – C1. Unreported opinion in *FMC Corp. v. Good Samaritan Hosp. of the Santa Clara Valley*, (No. C-88-3092-FMS) (N.D. Cal. 1988) – D1.

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

29 U.S.C. § 1144(a).

Section 514(b)(2) of ERISA provides:

> (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2).

At all times relevant to this action, Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 (the "Financial Responsibility Law") provided:

> In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under section 1719 (relating to coordination of benefits).

75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1984).

Section 1720 was amended on February 7, 1990 to provide, effective July 1, 1990:

> In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits paid or payable by a program, group contract or other arrangement whether primary or excess under section 1719 (relating to coordination of benefits).

75 Pa. Cons. Stat. Ann. § 1720 as amended February 7, 1990, effective July 1, 1990.

Section 1719 of the Financial Responsibility Law provides:

> (a) *General rule.* - Except for workers' compensation, a policy of insurance issued or delivered pursuant to this subchapter shall be primary. Any program, group contract or other arrangement for payment of benefits such as described in Section 1711 (relating to required benefits) 1712(1) and (2) (relating to availability of benefits) or 1715 (relating to availability of adequate limits) shall be construed to contain a provision that all benefits provided therein shall be in

excess of and not in duplication of any valid and collectible first party benefits provided in section 1711, 1712 or 1715 or workers' compensation.

(b) *Definition.* – As used in this section the term "program, group contract or other arrangement" includes, but is not limited to, benefits payable by a hospital plan corporation or a professional health service corporation subject to 40 Pa.C.S.Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

75 Pa. Cons. Stat. Ann. § 1719 (Purdon 1984).

STATEMENT OF THE CASE

FMC operates a self-funded employee benefit plan, the FMC Salaried Health Care Plan (the "Health Plan"), that pays the medical expenses incurred by FMC employees and their covered dependents.[1] FMC provides all funds used by the Health Plan to pay such medical benefits; FMC does not purchase insurance to provide these benefits.[2] (C1).

[1] The Health Plan is an employee welfare benefit plan as defined in ERISA, *see* 29 U.S.C. §§ 1002(1) and 1003(a)(1), because it was established and is maintained by FMC to provide beneficiaries with medical, surgical and hospital care benefits in the event of sickness, accident or disability. (J.A. 106). A copy of the Health Plan is included in the Joint Appendix. (J.A. 12-79).

[2] Self-funded plans cover a vast number of American workers. More than 9-1/2 million Americans are covered by

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The Health Plan seeks to contain costs by, among other ways, providing for the exercise of subrogation rights and for coordination of benefits. The Health Plan provides to FMC the following subrogation rights:

> The FMC self-insured benefit program is automatically assigned the right of action against third parties in any situation in which benefits are paid to employees or their dependents. If you bring a liability claim against any third party, benefits payable under this Plan must be included in the claim, and when the claim is settled you must reimburse the Plan for the benefits provided.

(C2).

In addition, the Health Plan provides for coordination of benefits as follows:

> If you or a covered member of your family are eligible to receive benefits under another group medical plan, Health Maintenance Organization (HMO), government plan, or by "no-fault" automobile insurance which provides medical coverage, you may be eligible for benefits from those Plans and your FMC plan. In the case of coverage by "no-fault" automobile insurance, FMC

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health plans that are self-funded. "Employee Benefits in Medium and Large Firms, 1988", U.S. Department of Labor, Bureau of Labor Statistics, Bulletin 2336 (August 1988). Moreover, a 1986 study by the Health Care Financing Administration (a division of the U.S. Department of Health and Human Services) revealed that four out of every five companies and unions with 5,000 or more plan participants operated self-funded health care plans. P. McDonnell, A. Guttenberg, L. Greenberg, R.H. Arnett III, "Self-Insured Health Plans," *HCFA Review*, Vol. 8 No. 2 (1986).

> will pay covered expenses not paid for by no-fault insurance.
>
> * * *
>
> No-Fault
>
> In some states with no-fault motor vehicle coverage, the carrier is the primary insurer in these jurisdictions. All medical expenses related to an accident must be submitted to the carrier and not the FMC Health Care Plan. Eligible expenses not paid for by no-fault insurance *will* be paid by the FMC Plan.

FMC Corp. v. Holliday, 885 F.2d 79, 80-81 (3d Cir. 1989), *cert. granted*, 110 S.Ct. 1109 (1990).

Gerald Holliday, an FMC employee, subscribed to FMC's Health Plan, and his daughter, Cynthia Ann Holliday ("Holliday"), was a covered dependent. (C1). Ms. Holliday was injured in a 1987 automobile accident. (C1). Pursuant to the Health Plan's coordination of benefits provisions, the first $10,000 of Ms. Holliday's medical expenses were paid through her father's State Farm automobile insurance policy, the so-called "no-fault" insurer referred to in the Health Plan's coordination of benefits provisions. *FMC*, 885 F.2d at 81. The Health Plan then paid a substantial portion of the remaining $178,000 in expenses. (C1).

Thereafter, FMC learned that the Hollidays had filed a tort action in Pennsylvania state court (the "Pennsylvania Action") against the negligent driver.[3]

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[3] On May 2, 1989, the court in the Pennsylvania Action approved a settlement agreement whereby $49,875.50 plus

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Invoking the terms of the Health Plan, FMC notified the Hollidays that it intended to exercise its subrogation rights with respect to any recovery. (C2). The Hollidays rejected FMC's claim, contending that Section 1720 of the Financial Responsibility Law prohibits such subrogation.[4] (C3). Thereupon, FMC sought a declaratory judgment from the district court.[5]

Both FMC and Ms. Holliday moved for summary judgment. The district court (Bloch, J.) found that no material facts were in dispute, denied FMC's motion, granted Ms. Holliday's motion and entered judgment in her favor. *FMC Corp. v. Holliday*, No. 88-1098 (W.D. Pa. 1989) (C1).

The court of appeals affirmed the district court's judgment, holding: (1) that Section 1720 of the Financial Responsibility Law applies to self-funded plans and precludes FMC from exercising its subrogation rights under the Health Plan, *FMC*, 885 F.2d at 83; (2) that Section 1720 of the Financial Responsibility Law does not conflict with a "core type of ERISA matter" that Congress sought

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accrued interest was placed in an escrow account in the name of Ms. Holliday pending the outcome of this action. *FMC*, 885 F.2d at 80.

[4] Before reaching the preemption question presented to this Court, both the district court and the court of appeals held that Section 1720 applies to self-funded plans such as the Health Plan. (C3-C7); *FMC*, 885 F.2d at 81-83.

[5] The district court's jurisdiction was invoked under 28 U.S.C. § 1332. FMC is incorporated in Delaware and has its principal place of business in Illinois; Holliday is a citizen of Pennsylvania.

to protect by the preemption provisions; and (3) that Section 514 of ERISA does not, therefore, preempt Section 1720 as applied to FMC's self-funded Health Plan. *Id.* at 83-90.

FMC filed a Petition for Writ of Certiorari citing the public importance of the ERISA preemption issue and the conflicting rulings of the several courts of appeals on this issue. The Petition was granted on February 20, 1990.

SUMMARY OF ARGUMENT

The Court of Appeals for the Third Circuit erred by holding that the Commonwealth of Pennsylvania, through a state insurance law, could prohibit FMC from including an enforceable subrogation provision in its self-funded employee benefit plan. The plain language of ERISA's preemption provisions allows states to regulate insurance products purchased by an employee benefit plan on the strength of the "insurance saving" clause, Section 514(b)(2)(A), but prohibits states from treating a benefit plan as if it were engaged in the business of insurance and directly controlling the terms of a self-funded benefit plan. As this Court held in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), proper interpretation of ERISA's so-called "deemer clause," Section 514(b)(2)(B), limits the scope of the insurance saving clause, thus entirely shielding self-funded plans from the effects of state insurance regulation. ERISA expressly preempts the application of Section 1720 of the Financial Responsibility Law to self-funded benefit plans, such as the Health Plan.

To reach its result, the court of appeals misread ERISA's legislative history and erroneously narrowed the scope of preemption as applied to self-funded plans to situations where state insurance regulation impinges on core ERISA concerns. As this Court recognized in *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983), and *Metropolitan Life*, Congress specifically rejected limiting preemption to those situations where state laws conflicted with certain of the substantive mandates of ERISA, but instead mandated broad preemption. The court of appeals misconstrued the language of the deemer clause, drew unwarranted conclusions from ERISA's legislative history and defined the scope of the deemer clause in a manner directly contrary to congressional intent.

Finally, preemption of state insurance regulations as applied directly to benefit plans furthers the fundamental purposes of ERISA. Congress sought nationally uniform regulation of employee benefit plans to relieve plans from the costly and complex administrative burden of complying with a patchwork scheme of conflicting state regulations. The clarity of the rule that prohibits states from directly regulating benefit plans, as opposed to the insurance products the plans may purchase, reduces opportunities for controversy, thus furthering Congress' efforts to protect plans from costly and protracted litigation. This Court's holding in *Metropolitan Life* advances those congressional goals. FMC's interpretation of the deemer clause achieves those results. The court of appeals' action does not.

ARGUMENT

Section 514 of ERISA Preempts Direct State Regulation of Self-Funded Employee Benefit Plans.

ERISA establishes a federal regulatory scheme for employee benefit plans and, as a general matter, expressly preempts state regulation of such plans. As an exception to that broad federal preemption, ERISA's insurance saving clause permits state regulation of the insurance industry. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), held that ERISA's deemer clause forbids direct state regulation of employee welfare benefit plans, although ERISA's insurance saving clause does permit indirect regulation of employee benefit plans that purchase state-regulated insurance products. *Id.* at 741, 747. Accordingly, the Court of Appeals for the Third Circuit erred in holding that an insurance regulation, *i.e.*, Section 1720 of Pennsylvania's Financial Responsibility Law, could be applied to FMC's self-funded Health Plan.

A. ERISA Requires Preemption of State Insurance Regulations As Applied Directly to Benefit Plans.

"The purpose of Congress is the ultimate touchstone" of every preemption question. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987) (citations omitted). Preemption "is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose." *Metropolitan Life*, 471 U.S. at 738. Accordingly, any preemption inquiry must "begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose."

Id. at 740 (quoting *Park'N Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. 189, 194 (1985)).

In considering the scope of preemption under ERISA, this Court has employed a three-part analysis that follows the language and structure of Section 514. *See, e.g., Pilot Life*, 481 U.S. at 45.[6] It is at the critical third step, the analysis of the deemer clause, where the Court of Appeals for the Third Circuit erred.

First, ERISA's broad preemption provision, Section 514(a), provides that ERISA shall preempt "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." § 514(a) of ERISA; 29 U.S.C. § 1144(a). "The phrase 'relate to' was given its broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to such a plan.'" *Metropolitan Life*, 471 U.S. at 739 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). Both the district court and the court of appeals held that the Pennsylvania Legislature intended Section 1720 of the Financial Responsibility Law to apply to employee benefit plans and that, under the terms of Section 514 of ERISA, Section 1720 "relates to" benefit plans such as the Health Plan. (C8-C9); *FMC*, 885 F.2d at 84-85. Indeed, Section 1720's relation to and effect on the Health Plan is dramatic – it prohibits FMC from exercising its contractual and common law subrogation rights.

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[6] The court of appeals belittled this Court's analysis of ERISA's preemption provisions as "[s]tating the obvious more than providing guidelines for surmounting [the] difficulties" in interpreting those provisions. *FMC*, 885 F.2d at 84.

Second, Congress sought uniform federal regulation of benefit plans but also faced the reality that preempting the area without exception would run afoul of its traditional deference to state regulation of the insurance industry. *See* McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.* (1976); *see also Metropolitan Life*, 471 U.S. at 743-44 (quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)). Thus, Congress created Section 514(b)(2)(A), the so-called insurance saving clause, which provides:

> [N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b)(A). The insurance saving clause does not allow the states to regulate directly the terms of employee benefit plans but rather preserves "the McCarran-Ferguson Act's reservation of the business of insurance to the states," *Metropolitan Life*, 471 U.S. at 744 n.21, by leaving to the states the regulation of *contracts of insurance* purchased by ERISA benefit plans.[7]

A state law "regulates insurance" if it meets the common sense requirement that it is specifically directed

[7] Congress' post-enactment understanding of the deemer clause is consistent with the view that states may regulate insurance products purchased by benefit plans but may not directly regulate the plans themselves. *See* H.R. Rep. No. 1785, 94th Congress, 2d Sess. 33, 48 (1977) ("[S]tate regulation of [insurance products] is not preempted by Section 514 even though such state action is barred with respect to the plans which purchase these 'products.' "); *see also Metropolitan Life*, 471 U.S. at 747 n.25 (relying upon the same report to discern congressional intent underlying the deemer clause).

toward some aspect of the insurance industry, or if it falls within the McCarran-Ferguson Act's definition of the business of insurance. *Pilot Life*, 481 U.S. at 48 (citing 15 U.S.C. §§ 1011 *et seq.*).[8] Both the district court and the court of appeals determined that the Financial Responsibility Law regulates insurance within the meaning of the insurance saving clause, and FMC does not contest this point on this appeal. *See FMC*, 885 F.2d at 86 (the Financial Responsibility Law's "coordination of benefits and antisubrogation provisions directly control the terms of insurance contracts").

Third, ERISA's deemer clause, Section 514(b)(2)(B), limits the scope of the insurance saving clause, providing:

> Neither an employee benefit plan nor any trust established under such a plan, shall be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for the purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts.

29 U.S.C. § 1144(b)(2)(B). Thus, the deemer clause precludes the states from treating an employee benefit plan

[8] The three factors relevant to whether a practice falls within the "business of insurance" under the McCarran-Ferguson Act are "*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." *Metropolitan Life*, 471 U.S. at 743, quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (emphasis in original).

as if it were engaged in the business of insurance.[9] This limitation has the effect of barring the states from applying directly to an employee benefit plan state insurance laws that are saved from preemption by the insurance saving clause. In other words, the deemer clause places self-funded plans, such as the Health Plan, entirely beyond the reach of state insurance regulation.[10] The court of appeals ignored the plain language of the deemer clause and, invoking the insurance saving clause, applied Section 1720 of the Financial Responsibility Law directly to the Health Plan, invalidating its subrogation rights.

B. This Court's Decision in *Metropolitan Life* Recognized That ERISA Allows States to Regulate ERISA Benefit Plans Only Indirectly Through Regulation of Insurance Companies And Their Products.

Metropolitan Life held that ERISA did not preempt a Massachusetts statute that required insurers, and thus *insured* employee health-care plans, to provide minimum mental-health-care benefits to Massachusetts residents. *Metropolitan Life*, 471 U.S. at 738-47.[11] This Court analyzed

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[9] Black's Law Dictionary defines "deem" as follows:

> **Deem.** To hold; consider; adjudge; believe; condemn; determine; *treat as if*; construe. Black's Law Dictionary 374 (5th ed. 1979) (emphasis added).

[10] On the other hand, insured benefit plans are subject to indirect regulation only because states may regulate the insurance products they purchase, not the plans themselves.

[11] Massachusetts conceded that the "mandated-benefits" statute at issue could not reach self-funded benefit plans in light of the deemer clause. *Id.* at 735, n.14.

the structure of Section 514 of ERISA, in particular the relationship between the insurance saving clause and the deemer clause. *Id.* at 740-41.

Specifically, the reach of the insurance saving clause was defined by reference to the purpose of the deemer clause:

> [T]he deemer clause makes explicit Congress' intention to include laws that regulate [the terms of] insurance contracts within the scope of the insurance laws preserved by the saving clause. Unless Congress intended to include laws regulating insurance contracts within the scope of the insurance saving clause, *it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans.*

Id. at 741 (emphasis added). Accordingly, state laws regulating the terms of insurance contracts, such as the anti-subrogation provision of the Financial Responsibility Law, are explicitly exempted "from the saving clause [and thus preempted by ERISA] when they are applied directly to benefit plans." *Ibid.*[12]

This Court concluded:

> Our decision results in a distinction between insured and uninsured plans, leaving the former

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[12] Section 1720 of the Financial Responsibility Law regulates the terms of insurance contracts as did the mandated benefits provision in *Metropolitan Life*: Section 1720 limits the provisions that may be included in insurance contracts whereas the Massachusetts statute required such contracts to include particular provisions.

> open to indirect regulation while the latter are not. By so doing, we merely give life to a distinction Congress is aware of and one it has chosen not to alter.

Id. at 747 (footnote omitted). Thus, Pennsylvania may regulate the terms of insurance contracts, including those purchased by employee benefit plans. The antisubrogation provision of Section 1720 does just that. But Pennsylvania may not directly or indirectly regulate a self-funded employee benefit plan that does not purchase any insurance products. Contrary to the holding of *Metropolitan Life*, the court of appeals' decision erroneously permits Pennsylvania to encroach upon this federally preempted area.

C. The Test Adopted By the Court of Appeals Contravenes This Court's Decision in *Metropolitan Life* and Is Inconsistent With The Weight of Appellate Authority.

Since *Metropolitan Life*, seven courts of appeals have interpreted the deemer clause. With two exceptions, those courts have read *Metropolitan Life* and the deemer clause to mandate preemption of all state insurance laws as applied directly to self-funded plans.[13] Only the Courts of

[13] The courts of appeals are in conflict in their interpretation of the deemer clause: *Compare Baxter v. Lynn*, 886 F.2d 182, 186 (8th Cir. 1989) (noting that even if state subrogation law had been saved from preemption as a law that regulated insurance, the deemer clause of Section 514 clearly prevents application of the subrogation law to a self-funded benefit plan) *and Reilly v. Blue Cross and Blue Shield United of Wisconsin*,

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Appeals for the Third Circuit in *FMC* and the Sixth Circuit in *Northern Group Services Inc. v. Auto Owners Ins. Co.*, 833 F.2d (6th Cir. 1987), *cert. denied*, 108 S.Ct. 1754 (1988), have disregarded *Metropolitan Life*. Indeed, the Third

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846 F.2d 416, 425-26 (7th Cir.), *cert. denied*, 109 S.Ct. 145 (1988) (holding that, regardless whether plaintiff's state law claims fall within insurance saving clause, Section 514 of ERISA preempts those claims when made against self-funded benefit plan) *and Insurance Bd. of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 410-13 (3d Cir. 1987) (holding that Pennsylvania's mandated benefits law could not be applied to a self-funded benefit plan because it was preempted by ERISA) *and United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1161-62 (9th Cir. 1986) (holding that Section 514 of ERISA prevents application of Arizona antisubrogation law to self-funded benefit plan) *and Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419, 423 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (holding that Section 514 of ERISA prevents application of Virginia insurance trade practice laws to self-funded benefit plan) *and Children's Hosp. v. Whitcomb*, 778 F.2d 239, 242 (5th Cir. 1985) (holding that Section 514 of ERISA prevents application of a Louisiana mandatory benefits law to a self-funded benefits plan) *with FMC Corp. v. Holliday*, 885 F.2d 79, 89-90 (3d Cir. 1989), *cert. granted*, 110 S.Ct. 1109 (1990) (holding that Pennsylvania antisubrogation law as applied to self-funded benefit plan was not preempted by Section 514 of ERISA because the Pennsylvania law did not address "a core type of ERISA matter which Congress sought to protect by the preemption provision") *and Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 89-93 (6th Cir. 1987), *cert. denied*, 108 S.Ct. 1754 (1988) (holding that Michigan coordination of benefits law as applied to self-funded benefit plan was not preempted by ERISA because there was no ERISA interest in uniformity which outweighed the interest in state regulation of insurance).

Circuit's decision in this case cannot be reconciled with a prior decision of the same court which interpreted the deemer clause to preempt state insurance regulations as applied to self-funded plans. *See Insurance Bd. of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 411 (3d Cir. 1987).[14]

In contrast to the decisions in *FMC* and *Northern Group Services*, the great majority of federal courts of appeals that have considered the application of state insurance laws to self-funded benefit plans has relied upon the deemer clause and the reasoning of *Metropolitan Life*; those courts have consistently held that state insurance law cannot reach self-funded employee benefit plans.

The decisions by the Courts of Appeals for the Eighth Circuit in *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989), and for the Ninth Circuit in *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986), are particularly apposite to this case. In *Baxter* and *Pacyga*, participants in self-funded benefit plans were injured in motor vehicle accidents, collected medical benefits from their plans and asserted claims for damages against third-party tortfeasors. *Baxter*, 886 F.2d at 184; *Pacyga*, 801 F.2d at 1158-59. In both cases, the employee benefit plans sought reimbursement of medical expenses paid on behalf of the plans' participants pursuant to subrogation provisions

[14] The *Muir* court noted that ERISA's preemption scheme allows states to regulate any entity engaged in the business of insurance but does not permit direct regulation of ERISA benefit plans. *Id.* at 411.

contained in the plans; the beneficiaries insisted that state law prohibitions against subrogation voided the plans' subrogation rights. *Baxter*, 886 F.2d at 184; *Pacyga*, 801 F.2d at 1159. In both cases, the courts of appeals, relying on *Metropolitan Life*, concluded that the deemer clause operated to prevent state antisubrogation laws from reaching self-funded benefit plans. *Baxter*, 886 F.2d at 186; *Pacyga*, 801 F.2d at 1161-62.

Although confronted with different factual circumstances, other federal appellate courts in the majority have reached the same fundamental conclusion: ERISA's broad preemption provision, Section 514(a), and the deemer clause, Section 514(b)(2)(B), operate to preempt state insurance laws as applied directly to self-funded employee benefit plans. For example, in *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986), a beneficiary of a self-funded plan sought damages for her employer's alleged breach of an implied covenant of good faith and fair dealing and for violations of the Virginia Unfair Trade Practice Act, both of which apply to insurers. *Id.* at 422. The court held that the deemer clause protected the employer from such claims. *Id.* at 423. Similarly, in *Reilly v. Blue Cross and Blue Shield of Wisconsin*, 846 F.2d 416 (7th Cir.), *cert. denied*, 109 S.Ct. 145 (1988), the court relied upon the deemer clause to hold that a plan beneficiary's state law claims for bad faith and punitive damages could not reach the self-funded plan at issue. *Id.* at 425-26. Finally, in *Children's Hosp. v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985), a state insurance statute required employers to structure their benefit plans to provide the same level of benefits for mental health problems and for all other illnesses. *Id.* at 241. Relying upon *Metropolitan Life*, the court determined

that the deemer clause prohibited application of this statute to self-funded plans. *Id.* at 242.

Despite the language of ERISA, despite *Metropolitan Life* and despite the great weight of authority from other courts of appeals, the Third Circuit applied the anti-subrogation provision of the Financial Responsibility Law to FMC's self-funded Health Plan and fashioned a new test that sharply limits the accepted meaning of the deemer clause and expands the reach of the insurance saving clause:

> [T]he proper inquiry under the deemer clause is whether the state insurance regulation intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect by the preemption provision. The court, reviewing a state insurance law, should inquire whether that law conflicts with any substitute (sic) mandate in ERISA.

FMC, 885 F.2d at 89-90. Notwithstanding its promulgation of this new test, the court of appeals acknowledged that the deemer clause, as interpreted in *Metropolitan Life*, requires courts to prohibit the application of at least some state insurance laws directly to self-funded plans. The court then turned its back on the *Metropolitan Life* interpretation of the deemer clause, labelling it "dicta," and held that "insured plans would *per se* survive the deemer clause, while self-insured plans would merely be considered on a case-by-case basis as to whether the state regulation involved affects a central concern of ERISA." *FMC*, 885 F.2d at 89.[15]

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[15] In *Northern Group Services*, the Court of Appeals for the Sixth Circuit also acknowledged that the deemer clause

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The fundamental flaw in the reasoning in *FMC* is its determination that self-funded plans are, in fact, "in the business of insurance" for non-core ERISA matters and are thus subject to state insurance regulation. That premise flies in the face of the deemer clause's plain statement that an employee benefit plan is not to be deemed, for any purposes or at any time, to be engaged in the business of insurance. The Third Circuit's novel and unsupported presumption rests not on the strength of binding case authority or legislative history but on its stated desire to have ERISA's interlocking preemption provisions "make sense." *FMC*, 885 F.2d at 88. However, this Court's reading of the deemer clause in *Metropolitan Life* as a limitation on the reach of the insurance saving clause makes perfect sense of the statutory scheme and is entirely in accord with congressional intent.[16]

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requires courts to limit the application of state insurance laws to self-funded plans. *Northern Group Services*, 833 F.2d at 94-95. That court, however, fashioned yet another test to determine whether regulation of self-funded plans was preempted:

> [I]n the absence of a showing of state purpose specifically to regulate the content of welfare benefits provided by ERISA, the effect of the deemer clause should be assessed by a balancing of the interests in federal uniformity against those of state primacy in the regulation of insurance.

Id. at 92-93.

[16] The *FMC* court underscored its refusal to apply the *Metropolitan Life* holding that state insurance laws may not be applied directly to self-funded plans by criticizing this

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Moreover, the test fashioned by the court of appeals in *FMC* is remarkably similar to the preemption test that was rejected in *Metropolitan Life*. This Court held there that "[n]othing in the language, structure, or legislative history of [ERISA] supports the [Massachusetts] Supreme Judicial Court's attempt to save only state regulations unrelated to the substantive provisions of ERISA." *Metropolitan Life*, 471 U.S. at 746-47. Similarly, nothing in the language, structure or legislative history of ERISA supports the attempt of the court below to preempt state regulation of self-funded benefit plans only where state laws affect a core type of ERISA matter or conflict with any substantive mandate in ERISA. *FMC*, 885 F.2d at 89-90.[17]

Thus, the deemer clause, as interpreted by this Court in *Metropolitan Life*, by the Third Circuit in *Muir*, and by the Fourth, Fifth, Seventh, Eighth and Ninth Circuits, prohibits the application of any state insurance law to a self-funded employee benefit plan. The court in *FMC* erred when it failed to apply this bright-line test.

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Court's opinion, stating that this Court had "cited neither statutory text nor legislative history" in reaching its conclusion regarding the scope of the deemer clause. *FMC*, 885 F.2d at 89.

[17] While the test rejected in *Metropolitan Life* related to the insurance saving clause, this Court's reasoning applies with full force to the test fashioned in *FMC*. Both the Supreme Judicial Court of Massachusetts and the Third Circuit sought to alter the scope of the saving clause, the former seeking to limit it, the latter seeking to expand it, through the vehicle of conflict-based tests. No justification exists for either attempt.

Moreover, as demonstrated below, it fashioned a preemption standard that is inconsistent with the legislative history of ERISA and fundamentally subversive of Congress' purposes in broadly preempting state regulation of employee benefit plans.

D. The Court Of Appeals' Misreading Of ERISA's Legislative History Led To Unwarranted Restrictions On The Deemer Clause.

The court of appeals relied on an unsupportable reading of ERISA's legislative history to reject the teaching of *Metropolitan Life*, expand the insurance saving clause and restrict the role of the deemer clause. The result is impairment of the general preemption mandated by Section 514(a). Under the court's novel test, states may deem self-funded plans to be engaged in the business of insurance for the purpose of regulating "non-core" aspects of plans, a concept for which there is not the slightest support in either ERISA or its legislative history.

Congress made the express preemption provisions of ERISA "deliberately expansive," and "House and Senate sponsors emphasized both the breadth and importance of the preemption provisions." *Pilot Life*, 481 U.S. at 45-46 (citations omitted). In fact, the bill's original preemption provision--limiting preemption "only to state laws relating to specific subjects relating to ERISA"—was changed to reflect Congress' desire to preempt the entire field with regard to benefit plans. *Shaw*, 463 U.S. at 98-99. In *Shaw*, this Court relied on that change to hold that Section 514(a) preempts *more than* "laws dealing with the subject

matters covered by ERISA – reporting, disclosure, fiduciary responsibility and the like." *Id.* at 98.

In contrast to its creation of a sweeping general preemption provision, Congress, through the insurance saving clause, fashioned an exception to allow the states to maintain their historical power to regulate insurance coverage, while ensuring, through the deemer clause, that states could not expand this exception by treating benefit plans themselves as though they were insurance companies subject to state regulation. The court of appeals, in creating its deemer clause test, undermined the congressional will to make Section 514(a) expansive by erroneously narrowing the scope of preemption as applied to self-funded plans to situations where the state insurance regulation impinges on a "core" ERISA concern, such as "reporting, disclosure, and nonforfeitability." *FMC*, 885 F.2d at 88. Nothing in ERISA or its legislative history suggests that Congress sought to expand the breadth of the insurance saving clause to the detriment of ERISA's general preemptive scope, a result inherent in the court of appeals' deemer clause test.

Moreover, in concluding that the deemer clause is limited to core ERISA concepts, the courts of appeals in *FMC* and in *Northern Group Services* revisited the same legislative history that led this Court to a contrary decision concerning the respective reach of the insurance saving and deemer clauses in *Metropolitan Life*. *Compare Metropolitan Life*, 471 U.S. at 745-46, nn. 23-24, *with FMC*, 885 F.2d at 87 *and Northern Group Services*, 833 F.2d at 93,

n.3. Nowhere in *Metropolitan Life* did this Court mention the concern so prominent in the *FMC* and *Northern Group Services* opinions, *i.e.*, that by use of the deemer clause Congress sought to prevent only "back-door" or "pretextual" attempts by the states to regulate ERISA plans. *See FMC*, 885 F.2d at 86-88 *and Northern Group Services*, 833 F.2d at 92-93. In fact, the analysis of the legislative history undertaken by the Third and Sixth Circuits is incorrect.

The court below attached special significance to Congress' use of the phrase "purporting to regulate" in the deemer clause, noting that "the use of 'purporting' betokens a congressional concern only for regulation that was merely a pretext for impinging upon ERISA plans." *FMC*, 885 F.2d at 86-87. This construction is at odds with the ordinary meaning of the statutory language.[18] Laws which purportedly regulate insurance companies or contracts are merely laws which have the appearance or legal

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[18] Black's Law Dictionary defines "purport" and "pretext" as follows:

> **Purport**, n. Meaning; import; substantial meaning; substance; legal effect. The "purport" of an instrument means the substance of it as it appears on the face of the instrument, and is distinguished from "tenor," which means an exact copy.
>
> **Purport**, v. To convey, imply or profess outwardly; to have the appearance of being, intending, claiming, etc.
>
> **Pretext**. Ostensible reason or motive assigned or assumed as a color or cover for the real reason or motive; false appearance, pretense.

Black's Law Dictionary 1069, 1112 (5th ed. 1979) (citations omitted).

effect of regulating insurance companies or contracts. Congress' use of "purportedly" does not imply that the deemer clause was directed at deceit or surreptitiousness on the part of state legislatures.

Furthermore, the test devised by the Third Circuit does not correspond to the reasoning used to justify its adoption. The test does not simply eradicate pretextual use by state legislatures of insurance, banking or securities regulation for the purpose of regulating ERISA plans; it actually exempts all non-core matters, whatever they might be, from the scope of the deemer clause.

The court of appeals also relied on changes to the scope of ERISA's broad preemption section during the legislative process to justify its treatment of the deemer clause. This reliance is misplaced. The court noted that the first version of the deemer clause appeared in a bill which contained the original, narrow version of Section 514(a), *i.e.*, the version preempting only those state laws relating to the reporting, disclosure or fiduciary aspects of ERISA. *FMC*, 885 F.2d at 87. Thereafter, when the Conference Committee expanded Section 514(a) to preempt all state laws which relate to any employee benefit plan, it kept the deemer clause without change. *Id.* at 87-88. Because the deemer clause was virtually unchanged, the court below concluded that "retention of the deemer clause in the face of the expanded preemption clause indicates that the deemer clause in effect was meant to do the more narrow, specified work which the original version of the preemption clause was meant to do." *Id.* at 88.

That conclusion defies logic. Congress' revisions to Section 514(a) have no bearing on the meaning of the deemer clause, the purpose of which, as made clear by this Court in *Metropolitan Life*, is to define and limit the scope of the insurance saving clause. In fact, the Courts of Appeals for the Third and Sixth Circuits have misconceived the purposes of Congress, leading them to an incorrect and undesirable result.

E. Enforcing The Deemer Clause As A General Limitation On The Insurance Saving Clause Furthers The Purposes Of ERISA.

The many benefits which Congress sought to achieve through its enactment of a broad preemption provision are preserved by the deemer clause's limitation on the insurance saving clause.

First, Congress established benefit plan regulation as exclusively a federal concern to minimize the need for interstate employers such as FMC to structure and administer their plans differently in each state in which they have employees. *Shaw*, 463 U.S. at 105.[19] Congress recognized the administrative realities of employee benefit plans and sought to promote an employer's capacity to

[19] *See also* 120 Cong. Rec. 29942 (1974) (statement of Senator Jacob Javits) ("[T]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required – but for certain exceptions – the displacement of State action in the field of private employee benefit programs") and 120 Cong. Rec. 29933 (1974) (statement of Sen. Harrison Williams, Jr.) (preemption of the field intended to apply in its broadest sense with only the exceptions specified in the act).

provide benefits to employees scattered throughout many states in the most efficient manner, *i.e.*, through a single employee benefit plan. *Id.* at 105 n.25. As this Court stated in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987):

> It is thus clear that ERISA's preemption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Preemption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Id. at 11.

The court of appeals' holding subjects benefit plans to conflicting or inconsistent state laws at great costs to the plans – and at the ultimate expense of plan participants and beneficiaries.[20] Indeed, FMC's Health Plan has already been subjected to conflicting decisions regarding

[20] The court of appeals' opinion paves the way for a direct assault on the cost-containment efforts of self-funded plans, such as the Health Plan. That Plan contains costs through subrogation. The inability to exercise this contract right, because of the Financial Responsibility Law's antisubrogation provision, may force the Health Plan to reduce benefits to participants and beneficiaries. Congress feared this very scenario and drafted ERISA's preemption provisions with a broad brush to prevent its occurrence.

the application of state antisubrogation laws. A district court in California held, in direct conflict with this case, that a California antisubrogation statute is preempted as applied to FMC's Health Plan. *See FMC Corp. v. Good Samaritan Hosp. of the Santa Clara Valley*, No. C-88-3092-FMS (N.D. Cal. 1988) (D1). It is precisely the burden of having to comply with multiple and conflicting insurance regulations that ERISA's preemption provisions are intended to avoid. *See Fort Halifax*, 482 U.S. at 10.

Second, Congress believed that ease of administration resulting from nationally uniform regulation encourages employers to establish benefit plans without sacrificing protection of plan participants and beneficiaries.[21] Elimination of conflicting and inconsistent regulation encourages the establishment of plans by reducing their administrative and litigation costs. *Id.* at 11. However, this incentive for employers did not come at the expense of plan participants and beneficiaries. Plan participants and beneficiaries are protected by the reporting, disclosure and fiduciary requirements of ERISA, *see* 29 U.S.C. § 1001(b), and by the economic realities of the employer-employee relationship. *See* Goetz, *Regulation of*

[21] *See* Staff of Senate Comm. on Labor and Public Welfare, 94th Cong. 2d Sess., *reprinted in* Legislative History of ERISA 4670 (Comm. Print 1976) (statement of U.S. Rep. John Dent) ("I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent state and local regulation.").

Uninsured Employee Welfare Plans Under State Insurance Laws, 1967 Wis. L. Rev. 319, 345 (1967). Thus, application of state insurance statutes directly to benefit plans frustrates congressional goals without returning any real benefits to plan participants.

Finally, the clarity of the rule which limits states to regulation of insurance products and insurance companies and which prevents states from regulating the plans themselves will substantially reduce the likelihood of litigation concerning the validity of state action.[22] Congress rejected a case-by-case approach with respect to Section 514(a) because "it raised the possibility of endless litigation over the validity of state action that might impinge on Federal regulation." *FMC*, 885 F.2d at 88 (*quoting* Senator Javits).[23] The vague, case-by-case tests of the Third and Sixth Circuits invite precisely the type of endless litigation that ERISA's drafters sought to

[22] The large number of courts that have struggled with the issue of application of state insurance regulation directly to benefit plans demonstrates the need for a bright-line rule governing the issue. *See, e.g.*, note 13, *supra*.

[23] Senator Javits, one of the architects of ERISA, explained that Congressmen viewed earlier versions of House and Senate bills defining the perimeters of preemption in relation to the areas regulated by ERISA as problematic since "[s]uch a formulation raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme." 120 Cong. Rec. 29942 (1974).

preclude.[24] If the holding below is allowed to stand, much ingenuity will be brought to bear by future advocates on the subject of which matters are core ERISA concerns and which are not.

If the "core ERISA matter" test were to be adopted, plan administrators would be burdened with ascertaining, for each state in which covered employees reside, which insurance regulations may be applicable to their plans and which of those regulations implicate core ERISA concerns.[25] Adding to this substantial and costly burden is the fact that the Third Circuit's core concern test provides scant guidance upon which plan administrators and participants may base their everyday decisions regarding the applicability of state insurance regulation. Ultimately, plan administrators and participants will repeatedly resort to the courts for that guidance, thus frustrating Congress' efforts to discourage

[24] The malleability of the case-by-case approach is vividly illustrated by the Sixth Circuit's decision in *Liberty Mutual Ins. Group v. Iron Workers Health Fund of E. Michigan*, 879 F.2d 1384 (6th Cir. 1989), where the Sixth Circuit applied the test set forth in *Northern Group Services* but reached an opposite conclusion regarding the preemption of the same Michigan insurance statute that was at issue in *Northern Group Services*. *See Liberty Mutual*, 879 F.2d at 1387-88.

[25] On the other hand, insurers providing insurance policies to benefit plans would not be burdened with the task of determining which insurance regulations implicate core ERISA concerns because state insurance regulations are always applicable to their policies.

litigation over the permissible scope of state regulation. The bright-line rule established by ERISA itself and articulated in *Metropolitan Life* makes such litigation unnecessary.

CONCLUSION

Congress expressly rejected an opportunity to preempt only those state laws which conflict with core ERISA concerns when it enacted Section 514(a). Accordingly, in *Shaw*, this Court recognized Congress' decision and rejected an attempt to limit preemption under Section 514(a) only to those "laws dealing with subject matters covered by ERISA – reporting, disclosure, fiduciary responsibility and the like." *Shaw*, 463 U.S. at 98. Similarly, in *Metropolitan Life* this Court rejected an interpretation of the insurance saving clause that saved from preemption "only state laws that were unrelated to the substantive provisions of ERISA." *Metropolitan Life*, 471 U.S. at 736. Now, yet another judicial incarnation of the same conflict-oriented test has arisen, only this time it is the deemer clause that is at issue and the test takes the form of "core ERISA concerns." Like other conflict-oriented tests previously rejected by this Court, this latest variant must also be dismissed. The decision of the Court of

Appeals for the Third Circuit should be reversed, and judgment should be entered in favor of FMC.

Respectfully submitted,

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